Supreme Court, U.S.
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No. 91-1297

In the Supreme Court of the United States

OCTOBER TERM, 1991

OHIO DEPARTMENT OF HUMAN SERVICES
Petitioner,

VS.

OHIO HOSPITAL ASSOCIATION, et al.,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE SUPREME COURT OF OHIO

BRIEF FOR THE RESPONDENTS IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether a reduction by a State in existing Medicaid reimbursement rates for outpatient hospital services that was imposed solely to meet budgetary constraints without regard to whether the payments pursuant to the reduction were consistent with efficiency, economy, and quality of care violates 42 U.S.C. Sec. 1396a (a) (30) (A).

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OPINIONS BELOW

The opinion of the Ohio Supreme Court, Pet. App. A1-A15, is reported at 62 Ohio St. 3d 97. The opinions of the Court of Appeals of Franklin County, Ohio, Tenth Appellate Disctrict, Pet. App. A.16-A39, and the Court of Claims, State of Ohio, Pet. App. A40-A69, are not reported.

JURISDICTION

Respondents do not take issue with Petitioner's statement respecting jurisdiction.

STATUTORY PROVISION INVOLVED

Respondents do not take issue with Petitioner's statement respecting the statutory provision involved.

STATEMENT OF THE CASE

In its Statement of the Case, Petitioner has selectively chosen certain findings of the Court of Claims a substantial number of which are irrelevant to the issue being presented to this Court.[1] The following additional facts of that Court are necessary for a proper understanding of this case.

Respondents brought suit in the Court of Claims, State of Ohio, alleging that Petitioner's implementation of Ohio Adm. Code 5101:3-2-20 was arbitrary, unreasonable, in violation of federal and state law, and in breach of contract. In finding in favor of the Respondents, the Court of Claims made the following factual determinations:

1. Petitioner was not contending that the Medicaid cuts in reimbursement for hospital outpatient services were made in response to a determination that Ohio hospitals were operating inefficiently. Finding of Fact ("FF") #29 (Pet. App. A49).

2. Petitioner did not conduct any study or analysis prior to implementing either the emergency or permanent rule versions of Ohio Adm. Code 5101:3-2-20 to

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[1]For example, the State's intention to adopt a prospective payment system for outpatient services has no bearing on the issue before this Court in that the prospective payment system was not adopted during the time period at issue and did not form the basis for the challenged reimbursement method.

determine that the reduction in cost-based reimbursement was:

a. reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities;

b. consistent with efficiency, economy, and quality of care;

c. adequate to assure availability of and access to Medicaid services;

d. adequate to assure that costs of Medicaid patients will not be borne by non-Medicaid patients.

FF #33 (Pet. App. A50-A51).

3. The adoption of Ohio Adm. Code 5101:3-2-20 was based solely on Petitioner's budgetary needs. FF #35 (Pet. App. A51).

4. Hospitals with high Medicaid outpatient utilizations, such as teaching hospitals, children's hospitals, and hospitals located in poverty areas absorb the majority of the Medicaid reductions and would suffer significantly greater injury from those reductions. Twenty-five percent (25%) of the total revenue loss of $16,000,000 would be absorbed by seven major teaching hospitals. Nearly nine percent (9%) of the total

Twelve percent (12%) of the total amount of the reductions would fall on one of these teaching hospitals — Cleveland Metropolitan General Hospital. Twelve percent (12%) of the total amount of the reductions would be absorbed by four children's hospitals. FF #40 (Pet. App. A52).

5. Under the reimbursement plan imposed by Ohio Adm. Code 5101:3-2-20, hospitals were unable to eliminate or reduce their losses on Medicaid outpatient services by reducing outpatient costs because any reduction in costs resulted in a further reduction in Medicaid reimbursement. FF #41 (Pet. App. A53).

6. To reduce or eliminate the revenue losses incurred pursuant to Ohio Adm. Code 5101:3-2-20 for hospital outpatient services, Ohio hospitals had done and, if the reductions continued, were considering doing, some or all of the following, none of which were consistent with quality of patient care:

   a. eliminating existing outpatient services and abandoning the expansion of outpatient services;

   b. eliminating financial incentives to physicians to participate in outpatient programs;

   c. laying off outpatient services personnel or allowing unfilled outpatient staff vacancies to remain unfilled;

   d. raising charges for outpatient services in an attempt to recover the unreimbursed Medicaid costs from non-Medicaid patients;

e. performing certain procedures on an inpatient basis rather than on an outpatient basis.

FF #42, 43 (Pet. App. A53).

7. The percentage reductions in cost reimbursement imposed by Ohio Adm. Code 5101:3-2-20, by design, required that the unreimbursed costs of Medicaid patients be shifted to non-Medicaid patients. FF #44 (Pet. App. A53).

The Franklin County Court of Appeals concurred in the Findings of Fact of the Court of Claims based not only upon the standard of review which requires deference to the trial court's evidentiary findings but, also, based upon the Court of Appeals' own review of the record in this case. See, Court of Appeals Decision at Pet. App. A30 ("[A] review of the voluminous record and transcript supports the trial court's conclusions.")[2]

With respect to Petitioner's assignments of errors related to federal law, the Court of Appeals stated:

> In sum, there is a dearth of evidence to suggest that ODHS applied the standard of Section 1396(a) (30) (A), Title 42, U.S. Code, prior to implementing Ohio Adm. Code 5101:3-2-20.
>
> ***

[2]The Court of Claims and the Court of Appeals also both found that Ohio Adm. Code 5101:3-2-20 had been readopted as an emergency rule in violation of Ohio Revised Code Sec. 119.03 (F) and became void ab initio as of its readoption on March 31, 1988. Court of Claims Decision at Pet. App. A65;Court of Appeals Decision at Pet. App. A35-A36. The permanent version of the rule was effective April 23, 1988. Pet. App. A47.

> The other provisions of federal law disputed by ODHS as being applicable and/or violated include Section 1396 (a) (13) (A), Title 42, U.S. Code (the Boren Amendment), Sections 1396 (a) (2) and 1395x(v) (1) (A), Title 42, C.F.R. Given our discussion above of Section 1396 (a) (30) (A), it is clear that, in enacting Ohio Adm. Code 5111:3-2-20 [sic], ODHS also failed to comply with any of the standards enunciated by those provisions. Even assuming, nonetheless, that the trial court erred in determining that one or all of the provisions applies under these facts, any error is non-prejudicial in light of our holding as to Section 1396 (a) (30) (A). Accordingly, assignments of error numbers two, five, six, seven, eight, nine, ten, and eleven...are not well-taken.

Court of Appeals Decision at Pet. App. A31-A32.

Petitioner then filed a Memorandum in Support of Jurisdiction with the Ohio Supreme Court raising two propositions of law — one based upon the Fourteenth Amendment to the United States Constitution (which the Ohio Supreme Court subsequently declined to consider), and one based upon 42 U.S.C. Sec. 1396a(a) (30) (A). Petitioner did not raise any issue with respect to the Court of Appeals' rejection of Petitioner's other assignments of error based upon federal law nor did the Ohio Supreme Court consider any such federal issues.

The Ohio Supreme Court affirmed the decision of the Court of Appeals mooting only that portion of the lower court's decision relating to the Fourteenth Amendment. See, Ohio Supreme Court Decision at Pet. App. A-9.

ARGUMENT IN OPPOSITION

Rule 10 of the Rules of the Supreme Court of the United States provides the character of reasons that will be considered by this Court in determining whether to exercise its jurisdiction. With respect to decisions by a state court of last resort, Rule 10 provides that consideration may be given:

(b) When a state court of last resort has decided a federal question in a way that conflicts with the decision of another state court of last resort or of a United States court of appeals.

(c) When a state court...has decided an important question of federal law which has not been, but should be, settled by this Court, or has decided a federal question in a way that conflicts with applicable decisions of this Court.

The decision of the Ohio Supreme Court in this case fails to meet any of these criteria. Rather, the decision is consistent with the plain language of the statute at issue and the decisions of federal courts. Accordingly, no special or important reasons exist which warrant this Court to exercise its jurisdiction.

In Wilder v. Virginia Hospital Association, 496 U.S. ___, 110. S. Ct. 2510, 110 L. Ed. 2d 455 (1990), this Court made clear that a State may not act arbitrarily and unreasonably in setting rates under the Medicaid program. Rather, the reasonableness of the rates set by the State must be judged "against the objective benchmark of an 'efficiently and economically operated facility' providing care in compliance

with federal and state standards while at the same time ensuring 'reasonable access' to eligible participants." Id., 496 U.S. at ___; 110 L. Ed. 2d at 473. Accord, AMISUB (PSL), Inc. v. State of Colorado Department of Social Services, 879 F.2d 789, 800 (10th Cir. 1989), cert. denied, ___ U.S. ___, 110 S. Ct. 3212, 110 L. Ed. 2d 660 (1990) (while a State may consider budgetary constraints, budgetary constraints cannot excuse noncompliance with federal Medicaid law).

Petitioner has come before this Court asking that it ignore Supreme Court precedent and the factual findings of the courts below in order that Petitioner may avoid its legally mandated duty. Petitioner's arguments are not supported by the law or the facts of this case and, therefore, do not justify this Court exercising its jurisdiction.

A. Interpretation of 42 U.S.C. Sec. 1396a(a) (30) (A)

In an attempt to create an argument for this Court to consider, Petitioner states that the Ohio Supreme Court erroneously construed 42 U.S.C. Sec. 1396a(a) (30) (A) as establishing a minimum Medicaid rate. The concept of "minimum rate," however, was never an issue with the courts below. As was stated by the Ohio Supreme Court:

> ODHS is correct in asserting that the statute does not set a minimum rate of reimbursement in recognition of the varying and limited nature of state resources...However, the courts below did not hold that Ohio Adm. Code 5101:3-2-20 violated a set minimum rate.

Ohio Supreme Court Decision at Pet. App. A6-A7; see also, Court of Appeals Decision at Pet. App. A29-A30 ("It is clear

from the trial court's decision that the issue was not whether hospitals were reimbursed at a minimum rate but, rather, whether ODHS complied with federally mandated standards in enacting Ohio Adm. Code 5101:3-2-20.").

This lawsuit was brought on several grounds including a claim that Petitioner failed to comply with the plain language of 42 U.S.C. 1396a(a) (30) (A). That statute provides, in pertinent part, that a State plan for medical assistance must provide methods and procedures as are necessary "to assure that payments are consistent with efficiency, economy, and quality of care."

In interpreting this provision, the Ohio Supreme Court found that the State was required to make findings that its rates were reasonable and adequate prior to implementation. Such an interpretation is consistent with the decisions of other courts which have interpreted Section 1396a(a) (30) (A). Lexington Management Co., Inc. v. Missouri Department of Social Services, 656 F. Supp. 36, 45 (W.D. Mo. 1986) (Section 1396a(a) (30) requires the State to fund providers at proper levels); Illinois Hospital Association v. Illinois Department of Public Aid, 576 F. Supp. 360, 370 (N.D. Ill. 1983) (State preliminarily enjoined from deferring 23.5% of final hospital reimbursement due to budgetary crisis because plan failed to satisfy federal requirement that Medicaid reimbursement rates be sufficient to insure quality care).

In the present case, the evidence presented to the courts below established that the payments in question were not consistent with efficiency, economy, and quality of care. Under the Petitioner's then current cost reimbursement principles, a hospital could recover only those costs determined by

Medicare and Medicaid auditors, pursuant to Medicare cost finding principles, to be both reasonable and necessary in rendering outpatient services. Ohio Adm. Code 5101:3-2-22. This formula was not disputed. Ohio Adm. Code 5101:3-2-20, however, took the amount which was calculated pursuant to Section 5101:3-2-22 and reduced this amount effective January 4, 1988, by 12% (8% after July 1, 1988) solely as a means of resolving budget problems i.e., the Petitioner substantially reduced the amount which the Petitioner had already determined was reasonable and necessary to the delivery of services to Medicaid patients.

As such, the actions of Petitioner were inherently unreasonable in that the Petitioner had taken a system which it had certified to the federal government as providing payments "which are consistent with efficiency, economy, and quality of care," and then arbitrarily reduced the payments by 12% and then 8% as a way of achieving budgetary savings (even though the reductions were not mandated by a budget deficit). Court of Clams Decision at Pet. App. A58. As was stated by the Tenth Circuit in AMISUB (PSL), Inc., 879 F.2d at 801 (citing Alabama Nursing Home Assn. v. Califano, 433 F.Supp. 1325, 1330 (M.D. Ala. 1977), rev'd and vacated in part on other grounds sub nom. 617 F.2d 388 (5th Cir. 1980)), "If a state could evade the requirements of the [Medicaid] Act simply by failing to appropriate sufficient funds to meet them, it could rewrite the congressionally imposed standards at will."

Based upon the particular facts of this case, the Ohio Supreme Court held that:

> Former Ohio Adm. Code 5101:3-2-20 violates Title XIX of the Social Security Act, Section 1396a(a) (30) (A), Title 42, U.S. Code, because it was implemented solely for budgetary reasons, without consideration of its effect on the quality of care provided by the Medicaid program.

Ohio Supreme Court Decision at Pet. App. A1, para. 1 of syllabus.

Accordingly, the cases cited by Petitioner for the proposition that Section 1396a(a) (30) (A) prescribes no minimum Medicaid rates are irrelevant to this case. Furthermore, in none of these cases did the courts hold that payments pursuant to a State plan were not subject to judicial scrutiny or that a State was permitted to make payments with total disregard as to whether they served the purposes of efficiency, economy, or quality of care. See, e.g., Briarcliff Haven, Inc. v. Department of Human Services of Georgia, 403 F. Supp. 1355, 1362 (N.D. Ga. 1975) (Section 1396a(a) (30) (A) does not require a specific minimum payment so long as payment made was consistent with efficiency, economy, and quality of care). The District Court for the Southern District of Ohio, in an analogous case, has also specifically rejected Petitioner's argument:

> Whether a "minimum fee" has been established begs the question. Certainly, if a rate is so low as to be unreasonable, it is below an acceptable minimum. The real questions are

whose survey and what factors should determine the reasonableness of the fee.

Ohio State Pharmaceutical Association v. Creasy, 587 F. Supp. 698, 708 (S.D. Ohio 1984).

As is further evident from the above, the issue before the Ohio Supreme Court was not purely one of law; rather, the issue before the Court was whether the facts established that the Petitioner had determined that the rate reductions were consistent with efficiency, economy, and quality of care prior to their implementation as is required by 42 U.S.C. Section 1396a(a)(30)(A).[3] It has long been a guiding principle of this Court that it will not hear cases which involve mixed questions of law and fact or which "involve or imply conclusions or judgment by the Court upon the effect of facts adduced in the

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[3]The Court of Appeals also characterized Petitioner's argument as an evidentiary rather than legal dispute.

> ODHS does not dispute the applicability of Section 1396a(a)(30)(A) to this action. However, ODHS interprets the trial court's decision as requiring hospitals to be reimbursed one hundred percent of the costs they have incurred in providing outpatient services to Medicaid patients. Basically, ODHS challenges the manifest weight of the evidence....
>
> We cannot agree with the interpretation advanced by ODHS. It is clear from the trial court's decision that the issue was not whether hospitals were reimbursed at a minimum rate but, rather, whether ODHS complied with federally mandated standards in enacting Ohio Adm. Code 5101:3-2-20. The decision is replete with references to efficiency, economy, and quality of care, and the concomitant failure of ODHS to consider these standards....

Court of Appeals Decision at A29-A30. (Emphasis added.)

cause..." Pflueger v. Sherman, 293 U.S. 55, 58, 55 S.Ct. 10, 79 L.Ed. 193 (1934); Triplett v. Lowell, 297 U.S. 638, 648-49, 56 S.Ct. 645, 80 L.Ed. 949 (1935).

Applying the legal standard prescribed by Section 1396a(a)(30)(A) to the facts of this case, the Court of Claims held that (1) the reductions were not imposed because hospitals were inefficiently or uneconomically operated; (2) the reductions were implemented only as an unpreferred and unrecommended alternative to achieve the 10% budgetary savings that was anticipated under an alternative system which had been withdrawn by the Petitioner; and (3) the reductions were not mandated by a budget deficit. Court of Claims Decision at Pet. App. A57-A61.

Applying this legal standard to the facts of this case, the Court of Appeals held that there was "a dearth of evidence to suggest that ODHS applied the standard of Section 1396a(a)(30)(A)...." Court of Appeals Decision at Pet. App. A31.

Applying this legal standard to the facts of this case, the Ohio Supreme Court deferred to the finding of the Court of Claims that Section 5101:3-2-20 was adopted solely for budgetary reasons without consideration of its effect on the quality of care provided by the Medicaid program. The Court therefore found that Section 5101:3-2-20 was violative of 42 U.S.C. Sec. 1396a(a)(30)(A). Ohio Supreme Court Decision at Pet. App. A1 at para. 1 of syllabus, A9.

B. Applicability of 42 U.S.C. Sec. 1396a(a)(13)(A)

Petitioner further argues that the Ohio Supreme Court "erroneously engraphed [sic] the requirements of the Boren

Amendment onto 42 U.S.C. Sec. 1396a(a)(30)(A)" in reaching its decision. A plain reading of the Court's decision, however, reflects that this argument is also a misrepresentation of the Ohio Supreme Court's decision.

In analyzing this case, the Ohio Supreme Court recognized that the Medicaid statutes, in general, "impose a duty on state programs to adequately reimburse their Medicaid providers." Ohio Supreme Court Decision at Pet. App. A7. In support of this general proposition, the Court considered decisions interpreting the Boren Amendment, 42 U.S.C. Sec. 1396a(a)(13)(A), with respect to the issue of State cuts in Medicaid payments based solely upon budgetary concerns. Ohio Supreme Court Decision at Pet. App. A8-A9. At no time did the Court state that it was engrafting the requirements of the Boren Amendment onto Section 1396a(a)(30)(A) or otherwise basing its decision on any federal statute other than Section 1396a(a)(30)(A).[4] Nor did Petitioner raise any proposition of law regarding 42 U.S.C. Sec. 1396a(a)(13)(A) before the Ohio Supreme Court. The fact that Petitioner characterizes the Ohio Supreme Court's decision in such a manner does not create an issue justifying this Court exercising its jurisdiction.

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[4] Paragraph 1 of the syllabus in this case speaks solely to 42 U.S.C. Sec. 1396a(a)(30)(A) and does not mention Section 1396a(a)(13)(A). Rule 1 of the Ohio Supreme Court Rules for the Reporting of Opinions provides that with respect to Ohio Supreme Court opinions (other than those rendered per curiam), "The syllabus of a Supreme Court opinion states the controlling point or points of law decided in and necessarily arising from the facts of the specific case before the Court for adjudication." Accord, Baltimore & Ohio Railroad Co. v. Baillie, 112 Ohio St. 567, 567 para. 2 of syllabus (1925); Cassidy v. Glossip, 12 Ohio St. 2d 17, 24 (1967).

CONCLUSION

The Court of Claims of the State of Ohio, the Court of Appeals of Franklin County, Ohio, and the Ohio Supreme Court have each found that 42 U.S.C. Sec. 1396a(a) (30) (A) requires a State to consider, as part of its State plan for medical assistance, whether its rates will provide payments that are consistent with efficiency, economy, and quality of care. Based upon the evidence presented, as initially determined by the Court of Claims, and as subsequently reaffirmed by the Court of Appeals and the Ohio Supreme Court based upon an independent review of the record, these courts found that Petitioner's across-the-board cut was implemented by Petitioner solely based upon budgetary concerns and without regard to reasonableness, adequacy, or its effect on efficiency, economy, or quality of care.

As such, no legal issue has been presented in this petition which warrants consideration by this Court. The Ohio Supreme Court's decision was amply supported by both the law and the facts and is consistent with United States Supreme Court precedent.

Respondents therefore urge this Court to deny Petitioner's Petition for a Writ of Certiorari.

Respectfully submitted,

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APPENDIX

Rule 10. Considerations Governing Review on Writ of Certiorari

.1. A review on writ of certiorari is not a matter of right, but of judicial discretion. A petition for a writ of certiorari will be granted only when there are special and important reasons therefor. The following, while neither controlling nor fully measuring the Court's discretion, indicate the character of reasons that will be considered:

(a) When a United States court of appeals has rendered a decision in conflict with the decision of another United States court of appeals on the same matter; or has decided a federal question in a way in conflict with a state court of last resort; or has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of this Court's power of supervision.

(b) When a state court of last resort has decided a federal question in a way that conflicts with the decision of another state court of last resort or of a United States court of appeals.

(c) When a state court or a United States court of appeals has decided an important question of federal law which has not been, but should be, settled by this Court, or has decided a federal question in a way that conflicts with applicable decisions of this Court.

.2. The same general considerations outlined above will control in respect to a petition for a writ of certiorari to review a judgment of the United States Court of Military Appeals.

Rule 1. Supreme Court Opinions

(A) All opinions of the Supreme Court shall be reported in the Ohio Official Reports.

(B) The syllabus of a Supreme Court opinion states the controlling point or points of law decided in and necessarily arising from the facts of the specific case before the Court for adjudication.

(C) In a *per curiam* opinion of the Supreme Court, the point or points of law decided in the case are contained within the text of each *per curiam* opinion and are those necessarily arising from the facts of the specific case before the Court for adjudication.

§ 119.03 Procedure for adoption, amendment, or rescission of rules.

In the adoption, amendment, or rescission of any rule, an agency shall comply with the following procedure:

(A) Reasonable public notice shall be given at least thirty days prior to the date set for a hearing, in the manner and form and for the length of time as the agency determines and shall include:

(1) A statement of the agency's intention to consider adopting, amending, or rescinding a rule;

(2) A synopsis of the proposed rule, amendment, or rule to be rescinded or a general statement of the subject matter to which the proposed rule, amendment, or rescission relates;

(3) A statement of the reason or purpose for adopting, amending, or rescinding the rule;

(4) The date, time, and place of a hearing on the proposed action, which shall be not earlier than thirty nor later than fifty days after the proposed rule, amendment, or rescission is filed under division (B) of this section. In addition to public notice, the agency may give whatever other notice it considers necessary. Each agency shall adopt a rule setting forth in detail the method that the agency shall follow in giving public notice as to the adoption, amendment, or rescission of rules. The rule shall require the agency to provide the public notice

required under division (A) of this section to any person who requests it and pays a reasonable fee, not to exceed the cost of copying and mailing. The methods used for notification may include, but are not limited to, mailing notices to all subscribers on a mailing list or mailing notices in addressed, stamped envelopes provided by the person requesting the notice.

(B) One copy of the full text of the proposed rule, amendment, or rule to be rescinded, accompanied by one copy of the public notice required under division (A) of this section, shall be filed with the secretary of state. Two copies of the full text of the proposed rule, amendment, or rule to be rescinded, accompanied by two copies of the public notice required under division (A) of this section, shall be filed with the director of the legislative service commission. (If in compliance with this division an agency files more than one proposed rule, amendment, or rescission at the same time, and has given a public notice under division (A) of this section that applies to more than one of the proposed rules, amendments, or rescissions, the agency shall file only one copy of the notice with the secretary of state and only two copies of the notice with the director for all of the proposed rules, amendments, or rescissions to which the notice applies.) The proposed rule, amendment, or rescission and public notice shall be filed as required by this division at least sixty days prior to the date on which the agency, in accordance with division (D) of this section, issues an order adopting the proposed rule, amendment, or rescission. The proposed rule, amendment, or rescission shall be available for at

least thirty days prior to the date of the hearing at the office of the agency in printed or other legible form without charge to any person affected by the proposal. Failure to furnish such text to any person requesting it shall not invalidate any action of the agency in connection therewith. If the agency files a substantive revision in the text of the proposed rule, amendment, or rescission under division (H) of this section, it shall also promptly file one copy of the full text of the proposed rule, amendment, or rescission in its revised form with the secretary of state and two copies thereof with the director of the legislative service commission. The agency shall attach a copy of the rule summary and fiscal analysis prepared under section 121.24 or 127.18 of the Revised Code, or both, to each copy of a proposed rule or proposed rule in revised form that is filed with the secretary of state or the director of the legislative service commission.

(C) On the date and at the time and place designated in the notice, the agency shall conduct a public hearing at which any person affected by the proposed action of the agency may appear and be heard in person, by his attorney, or both, may present his position, arguments, or contentions, orally or in writing, offer and examine witnesses, and present evidence tending to show that the proposed rule, amendment, or rescission, if adopted or effectuated, will be unreasonable or unlawful.

At the hearing, the testimony, rulings on the admissibility of evidence, and proffers of evidence shall

be recorded by stenographic means. Such record shall be made at the expense of the agency.

In any hearing under this section the agency may administer oaths or affirmations.

The agency shall pass upon the admissibility of evidence, but the person affected may at the time make objection to the ruling of the agency, and if the agency refuses to admit evidence the person offering the evidence shall make a proffer of the evidence, and the proffer shall be made a part of the record of such hearing.

(D) After complying with divisions (A), (B), (C), and (H) of this section, and when the time for legislative review and invalidation under division (I) of this section has expired, the agency may issue an order adopting the proposed rule or the proposed amendment or rescission of the rule, consistent with the synopsis or general statement included in the public notice. At that time the agency shall designate the effective date of the rule, amendment, or rescission, which shall not be earlier than the tenth day after the rule, amendment, or rescission has been filed in its final form as provided in section 119.04 of the Revised Code.

(E) Prior to the effective date of a rule, amendment, or rescission, the agency shall make a reasonable effort to inform those affected by the rule, amendment, or rescission and to have available for distribution to those requesting it the full text of the rule as adopted or as amended.

(F) If the governor, upon the request of an agency, determines that an emergency requires the immediate adoption, amendment, or rescission of a rule, he shall issue a written order, a copy of which shall be filed with the secretary of state, the director of the legislative service commission, and the joint committee on agency rule review, that the procedure prescribed by this section with respect to the adoption, amendment, or rescission of a specified rule is suspended. The agency may then adopt immediately the emergency rule, amendment, or rescission and it becomes effective on the date copies of the rule, amendment, or rescission, in final form and in compliance with division (A) (2) of section 119.04 of the Revised Code, are filed as follows: two certified copies of the emergency rule, amendment, or rescission shall be filed with both the secretary of state and the director of the legislative service commission, and one certified copy of the emergency rule, amendment, or rescission shall be filed with the joint committee on agency rule review. If all copies are not filed on the same day, the emergency rule, amendment, or rescission shall be effective on the day on which the latest filing is made. The emergency rule, amendment, or rescission shall become invalid at the end of the ninetieth day it is in effect. Prior to that date the agency may adopt the emergency rule, amendment, or rescission as a nonemergency rule, amendment, or rescission by complying with the procedure prescribed by this section for the adoption, amendment, and rescission of nonemergency rules. The agency may not use the procedure of this division to readopt the emergency rule, amendment, or rescission so that, upon

the emergency rule, amendment, or rescission becoming invalid under this division, the emergency rule, amendment, or rescission will continue in effect without interruption for another ninety day period. This division does not apply to the adoption of any emergency rule, amendment, or rescission by the tax commissioner under division (C) (2) of section 5117.02 of the Revised Code.

(G) Rules adopted by an authority within the department of taxation or the bureau of employment services shall be effective without a hearing as provided by this section if the statutes pertaining to such agency specifically give a right of appeal to the board of tax appeals or to a higher authority within the agency or to a court, and also give the appellant a right to a hearing on such appeal. This division does not apply to the adoption of any rule, amendment, or rescission by the tax commissioner under division (C) (1) or (2) of section 5117.02 of the Revised Code, or deny the right to file an action for declaratory judgment as provided in Chapter 2721. of the Revised Code from the decision of the board of tax appeals or of the higher authority within such agency.

(H) When any agency files a proposed rule, amendment, or rescission under division (B) of this section, it shall also file with the joint committee on agency rule review two copies of the full text of the proposed rule, amendment, or rule to be rescinded in the same form and two copies of the public notice required under division (A) of this section. (If in compliance with this division an agency files more than one proposed rule, amendment, or rescission at

the same time, and has given a public notice under division (A) of this section that applies to more than one of the proposed rules, amendments, or rescissions, the agency shall file only two copies of the notice with the joint committee for all of the proposed rules, amendments, or rescissions to which the notice applies.) If the agency makes a substantive revision in a proposed rule, amendment, or rescission after it is filed with the joint committee, the agency shall promptly file two copies of the full text of the proposed rule, amendment, or rescission in its revised form with the joint committee. The latest version of a proposed rule, amendment, or rescission as filed with the joint committee supersedes each earlier version of the text of the same proposed rule, amendment, or rescission. An agency shall attach one copy of the rule summary and fiscal analysis prepared under section 121.24 or 127.18 of the Revised Code, or both, to each copy of a proposed rule, amendment, or rescission, and to each copy of a proposed rule, amendment, or rescission in revised form, that is filed under this division.

This division does not apply to:

(1) An emergency rule, amendment, or rescission;

(2) Any proposed rule, amendment, or rescission that must be adopted verbatim by an agency pursuant to federal law or rule, to become effective within sixty days of adoption, in order to continue the operation of a federally reimbursed program in this state, so long as the proposed rule contains both of the following:

(a) A statement that it is proposed for the purpose of complying with a federal law or rule;

(b) A citation to the federal law or rule that requires verbatim compliance.

(I)(1) The joint committee on agency rule review may recommend the adoption of a concurrent resolution invalidating a proposed rule, amendment, rescission, or part thereof if it finds any of the following:

(a) That the rule-making agency has exceeded the scope of its statutory authority in proposing the rule, amendment, or rescission;

(b) That the proposed rule, amendment, or rescission conflicts with another rule, amendment, or rescission adopted by thesame or a different rule-making agency;

(c) That the proposed rule, amendment, or rescission conflicts with the legislative intent in enacting the statute under which the rule-making agency proposed the rule, amendment, or rescission;

(d) That the rule-making agency has failed to prepare a complete and accurate rule summary and fiscal analysis of the proposed rule, amendment, or rescission as required by section 121.24 or 127.18 of the Revised Code, or both.

The house of representatives and senate may adopt a concurrent resolution invalidating a proposed rule, amendment, rescission, or part thereof. The concurrent resolution shall state which of the specific rules, amendments, rescissions, or parts thereof are invalidated. A concurrent resolution invalidating a proposed rule, amendment, or rescission shall be adopted prior to the sixtieth day after the original version of the text of the proposed rule, amendment, or rescission is filed with the joint committee, except that if more than thirty days after the original version is filed the rule-making agency files a revised version of the text of the proposed rule, amendment, or rescission, a concurrent resolution invalidating the proposed rule, amendment, or rescission shall be adopted prior to the thirtieth day after the revised version is filed. If, after the joint committee on agency rule review recommends the adoption of a concurrent resolution invalidating a proposed rule, amendment, rescission, or part thereof, the house of representatives or senate does not, within the time remaining for adoption of the concurrent resolution, hold five floor sessions at which its journal records a roll call vote disclosing a sufficient number of members in attendance to pass a bill, the time within which that house may adopt the concurrent resolution is extended until it has held five such floor sessions.

Within five days after the adoption of a concurrent resolution invalidating a proposed rule, amendment, rescission, or part thereof, the clerk of the senate shall send the rule-making agency, the secretary of state, and the director of the legislative service commission a certified copy of the resolution together with a certification stating the date on which the resolution takes effect. The secretary of state and the director of the legislative service commission shall each note the invalidity of the proposed rule, amendment, rescission, or part thereof on this copy, and

shall each remove the invalid proposed rule, amendment, rescission, or part thereof from the file of proposed rules. The rule-making agency shall not proceed to adopt in accordance with division (D) of this section, or to file in accordance with division (B) (1) of section 111.15 of the Revised Code, any version of a proposed rule, amendment, rescission, or part thereof that has been invalidated by concurrent resolution.

Unless the house of representatives and senate adopt a concurrent resolution invalidating a proposed rule, amendment, rescission, or part thereof within the time specified by this division, the rule-making agency may proceed to adopt in accordance with division (D) of this section, or file in accordance with division (B) (1) of section 111.15 of the Revised Code, the latest version of the proposed rule, amendment, or rescission as filed with the joint committee. If by concurrent resolution certain of the rules, amendments, rescissions, or parts thereof are specifically invalidated, the rule-making agency may proceed to adopt, in accordance with division (D) of this section, or to file in accordance with division (B) (1) of section 111.15 of the Revised Code, the latest version of the proposed rules, amendments, rescissions, or parts thereof as filed with the joint committee that are not specifically invalidated. The rule-making agency may not revise or amend any proposed rule, amendment, rescission, or part thereof that has not been invalidated except as provided in this chapter or in section 111.15 of the Revised Code.

(2) (a) A proposed rule, amendment, or rescission that is filed with the joint committee under division (H) of this section or division (D) of section 111.15 of the Revised Code shall be carried over for legislative review to the next succeeding regular session of the

general assembly if the original or any revised version of the proposed rule, amendment, or rescission is filed with the joint committee on or after the first day of December of any year.

(b) The latest version of any proposed rule, amendment, or rescission that is subject to division (1) (2) (a) of this section, as filed with the joint committee, is subject to legislative review and invalidat in the next succeeding regular session of the general assembly in the same manner as if it were the original version of a proposed rule, amendment, or rescission that had been filed with the joint committee for the first time on the first day of the session. A rule-making agency shall not adopt in accordance with division (D) of this section, or file in accordance with division (B) (1) of section 111.15 of the Revised Code, any version of a proposed rule, amendment, or rescission that is subject to division (I) (2) (a) of this section until the time for legislative review and invalidation, as contemplated by division (I) (2) (b) of this section, has expired.

(3) Invalidation of any version of a proposed rule, amendment, rescission, or part thereof by concurrent resolution shall prevent the rule-making agency from instituting or continuing proceedings to adopt any version of the same proposed rule, amendment, rescission, or part thereof for the duration of the general assembly that invalidated the proposed rule, amendment, rescission, or part thereof unless the same general assembly adopts a concurrent resolu-

tion permitting the rule-making agency to institute or continue such proceedings.

The failure of the general assembly to invalidate a proposed rule, amendment, rescission, or part thereof under this section shall not be construed as a ratification of the lawfulness or reasonableness of the proposed rule, amendment, rescission, or any part thereof or of the validity of the procedure by which the proposed rule, amendment, rescission, or any part thereof was proposed or adopted.

5101:3-2-22 Reasonable Cost Reimbursement for Hospital Services

(A) Applicability.
Reasonable cost reimbursement as set forth in this rule applies to:

(1) All outpatient services;

(2) All inpatient services associated with admissions occurring prior to [the] October 1, 1984;

(3) All inpatient services excluded from prospective payment as set forth in rule 5101:3-2-071 of the Administrative Code;

(4) All inpatient services provided under the general relief medical program as described in Chapter 5101:1-6 of the Administrative Code;

(5) All services provided by eligible providers of state-operated institutional psychiatric services as defined in rules 5101:3-2-11 to 5101:3-2-18 of the Administrative Code except that the provisions of 42 CFR 405.460 shall not apply to providers of state-operated institutional psychiatric services;

(6) All capital-related costs described in rule 5101:3-2-076 of the Administrative Code.

(B) Payments under reasonable cost reimbursement.

For hospital services subject to reasonable cost reimbursement, providers will be paid the lesser of reasonable costs or the billed charges for services furnished to eligible recipients. Hospital billings for such services must reflect the hospital's customary charge for the service rendered. Interim payments approximating the allowable costs as established by the provider's cost filings will be made as quickly as administratively feasible and will be computed on an individual basis determined by each institution's reported costs. Reported costs may be adjusted if they exceed predetermined reasonable amounts or if they are for unallowable items.

(1) For hospitals excluded from prospective payment, interim payments will be made by applying the hospital's ratio of total medicaid costs-to-total medicaid charges, expressed as a per cent, to billed charges.

(2) For all hospital services provided to general relief recipients, interim payments will be made by applying the hospital's ratio of total general relief costs-to-total general relief charges, expressed as a per cent, to billed charges.

(3) For outpatient services provided to medicaid recipients by hospitals subject to prospective payment, interim payments will be made by applying the hospital's ratio of total medicaid outpatient charges, expressed as a per cent, to billed charges.

(4) For out-of-state hospitals not subject to the cost-reporting provisions of rule 5101:3-2-23 of the Administrative Code and for new providers, the cost-to-charge ratios are based on the statewide average of the applicable type of ratio.

(5) For transplant services described in rule 5101:3-2-071 and for extraordinary outlier cases described in paragraph (A) (6) of rule 5101:3-2-079 of the Administrative Code, interim payments will be made by applying the hospital's ratio of total medicaid inpatient cost-to-total medicaid inpatient charges, expressed as a per cent, to billed charges except that organ acquisition and transportation costs will be paid at one hundred per cent of billed charges. The hospital-specific cost-to-charge ratio is determined by dividing the hospital-specific medicaid total costs, described in paragraph (D) (6) (e) of rule 5101:3-2-074 of the Administrative Code, by medicaid total charges described in paragraph (D) (6) (b) (i) of rule 5101:3-2-074 of the Administrative Code.

(C) In general, payment will be made for those items recognized as reasonable and allowable under Title XVIII standards and principles described in 42 CFR 405.401 through 405.466 and 405.480 through 405.482 except as otherwise provided in this paragraph. These Title XVIII standards and principles are applicable to those covered inpatient and outpatient hospital services as identified in rules 5101:3-2-01 to 5101:3-2-04 of the Administrative Code which are subject to reasonable cost reimbursement as described in this rule.

(1) The costs identified in paragraphs (C) (1) (a) to (C) (1) (f) of this rule are nonallowable.

(a) Cost of capital improvement or the cost of new equipment subject to a certificate of need approval after November 1, 1976 which has not been approved by the state health planning and development agency (P.L. 93-641).

(b) Cost of goods or services furnished free, by the hospital, or at less than fair market value. For example, the cost of office space or hospital employee time used to prepare physician invoices for physicians who invoice the department on a fee-for-service basis.

(c) Cost of services not reimbursable due to not having been billed timely as defined in rule 5101:3-1-193 of the Administrative Code.

(d) Cost of services which would be or are covered by a third-party payer as described in rule 5101:3-1-08 of the Administrative Code.

(e) The amount of any interest expense for money borrowed to alleviate cash flow problems resulting from rate reductions imposed for delinquent filing of cost reports as provided in rule 5101:3-2-23 of the Administrative Code.

(f) The amount of any interest on overpayments and any interest expense for money borrowed to alleviate cash flow problems resulting from an interest assessment as defined in rule 5101:3-1-25 of the Administrative Code.

(2) Provisions of Title XVIII related to prospective payment for inpatient hospital services as described

in 42 CFR 412.1 through 412.125 are not applicable to hospital services reimbursed under the provisions of this rule. Hospital services described in this rule are reimbursed under the provisions described in paragraphs (C) to (C) (1) (f) of this rule except in instances when those regulations have been altered to accommodate the Title XVIII prospective payment system as indicated in the examples that follow:

(a) Rescinded regulations 42 CFR 405.404, 405.423, and 405.428 as they existed on September 30, 1983, continue to apply under the provisions of this rule.

(b) Amendments made to 42 CFR 405.401 (d) (2) (i), 405.454 (a) (2), 405.454 (m), and 405.463 (c) (1) (iii) to implement Title XVIII prospective payment for certain hospitals are not recognized under the provisions of this rule.

(c) Amendments made to 42 CFR 405.460 (a) (1), 405.460 (h), 405.463 (a) (1), 405.463 (c) (1) (ii), and 405.463 (d) (1) (ii) to remove the applicability of those regulations for the Title XVIII prospective payment system for cost-reporting periods beginning on and after October 1, 1983, are not recognized under the provisions of this rule. Those regulations, as they existed on September 30, 1983, and as applicable to cost-reporting periods prior to those beginning on and after October 1, 1983, continue to apply for purposes of this rule.

(D) For hospitals paid on a prospective basis, a statewide ratio of total medicaid costs-to-total medicaid charges is used in payment for interim claims, as described in paragraph (C) (2) of the rule 5101:3-2-0711 of the Administrative Code. The statewide ratio is determined by summing, for all Ohio medicaid-participating hospitals, total medicaid inpatient charges from "Schedule H," section III, lines 14 and 15, and total medicaid inpatient costs from "Schedule H," section III, lines 6 and 7, then dividing the sum of total costs by the sum of total charges. This ratio is determined annually for each prospective rate year using cost and charge information from hospital cost-reporting periods which end in the calendar year preceding the prospective rate year.